Authorization for the Use and Disclosure of Protected Health Information

This authorization is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights to privacy with respect to your health care information.

Patient Name: **DOB:**

Address: **Suite/Apt #**

City **State** **Zip**

Reason for Release:

Information to be released: ☐ **All records** ☐ **Only records listed below**

Please check one: ☐ **Send my OGGI records to:** ☐ **I authorize OGGI to receive my records from:**

Name:

Phone: ( ) **Fax: ( )**

Address: **Suite/Apt #**

City **State** **Zip**

I give permission to OGGI to release all records contained in my chart from Ohio Gastroenterology Group, Inc including records received from other physicians or entities.
I understand that the information in my health record may include information relating to sexually transmitted Disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This authorization will expire on the following date, event, or condition, and shall not exceed one (1) year from today's date: _____. If I fail to specify an expiration date, this authorization will expire in sixty days.

I understand that by disclosing these records, the practice cannot guarantee the recipient will not re-disclose or use the records in a way that violates the privacy rules.

Under the privacy rules, I have the right to revoke this authorization at any time in writing, and OGGI must cease using this authorization. However, the practice may complete any actions initiated with my PHI prior to my revocation which rely on the above records for completion. (An example of this would be that your insurance coverage may rely on these records to contest a claim).

I must revoke this authorization in writing to:
Ohio Gastroenterology Group, Inc.
ATTN: Privacy/Security Board
3400 Olentangy River Road
Columbus, OH 43202

Patient/Guardian Signature Date

Printed Name Relationship to the patient (if signing as guardian)

❒ 3400 Olentangy River Road
Columbus, OH 43202
614-754-5500
Fax: 614-754-5501

❒ 6670 Perimeter Dr, Suite 200
Dublin, OH 43016
614-754-5500
Fax: 614-754-5501

❒ 85 McNaughten Rd, Suite 320
Columbus, OH 43213
614-754-5500
Fax: 614-754-5501

❒ 815 W. Broad St, Suite 220
Columbus, OH 43222
614-754-5500
Fax: 614-754-5501

❒ 450 Alkyre Run Dr, Ste 350
Westerville, OH 43082
614-754-5500
Fax: 614-754-5501

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